COMMISSION ON REHABILITATION SERVICES

APPLICATION

Name: _____ County: _____

Address: _____

City: _____State:_____Zip:_____

Work Phone: _____ E-Mail:_____Fax:_____

Home phone: _____ E-Mail: _____Fax:_____

1. Are you a person with a disability? If so, please indicate your disability below:

   _____Mental Health
   _____Mobility
   _____Deaf/Hard of Hearing
   ____Blind/Visually Impaired
   ____Cognitive
   ____Neurological

2. Are you a parent or sibling of a person with a disability?

   Yes No

Please tell us how you learned about the Commission on Rehabilitation Services and if you have had involvement with the Commission in the past.

3. Are you able to perform the duties of a member and make a commitment to attend a minimum of one regularly scheduled all-day meeting five times per year? If you were to be appointed to the Commission, how soon would you be available to begin serving on the Commission?

   Yes, I can begin serving_____ No_____

4. What do you believe are the most important issues facing people with disabilities today?
   _____

5. Please tell us a little about yourself and why you would like to be appointed to the Commission on Rehabilitation Services?
   _____

Upon request the Commission can provide accommodations that are necessary for you to participate in or attend meetings including: wheelchair access, ASL interpreters, attendant care, Braille, large print, cassette tape, etc.

If you have any questions about this application or the Commission on Rehabilitation Services, please contact: Kathy Sodeman, DDRS Staff support, 800-545-7763, Ext. 2-1350, voice or Relay Indiana; e-mail: kathy.sodeman@fssa.in.gov

NOTE: Application available in alternative formats upon request.

Please attach your resume and/or any other pertinent information. Include the following on your resume:

1. Educational history: Name and city of educational institution; dates attended; area of study; degree obtained (if any).
2. Employment history: Name, mailing address, job title, duties performed; dates of employment; contact name (e.g., immediate supervisor), and phone number with area code.
3. Volunteer/non-paid employment history: Name mailing address, volunteer title, duties performed; dates of volunteering; contact name (e.g., immediate supervisor), and phone number with area code.
4. Disability/advocacy-related training: Name, mailing address and phone
5. Number of organization sponsoring training, name of training, and dates of training.
6. Membership in disability/advocacy-related organizations. Offices held, committee assignments, description of activities performed, and dates for each.
7. Three (3) references (other than contact names provided above): name, mailing address, contact phone number, and how you know them.

Mail your completed application, resume and any attachments to:

Carol Baker, Bureau of Rehabilitation Services, Assistant Director
402 W. Washington Street Rm. W453
P.O. Box 7083
Indianapolis, IN 46207-7083

I hereby give permission for the Commission on Rehabilitation Services to contact any volunteer or advocacy organizations, and references.

Signature: _____ Date of Submission_____